Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

November 29, 2017

Ms. Mary Naumann, Manager
Willows Of Windsor
121 State Street
Windsor, VT 05089-1213

Dear Ms. Naumann:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on November 1, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0044	A. BUILDING: _____ B. WING _____	C 11/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS OF WINDSOR	121 STATE STREET WINDSOR, VT 05089

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite re-licensing survey and complaint investigation was conducted by the Division of Licensing and Protection from 10/31-11/1/17. There were no findings as a result of the complaint investigation. The following findings are a result of the survey:	R100		
R161 SS=C	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.b The manager of the home is responsible for ensuring that all medications are handled according to the home's policies and that designated staff are fully trained in the policies and procedures. This REQUIREMENT is not met as evidenced by: Based observation and staff interview, the facility Manager failed to ensure that all medications are handled according to the home's policies. The findings include the following: 1. Per inspection of the medication cart on 10/31/17 at approximately 10:40 AM the following was identified: -A bingo card containing twenty-three (23) tablets of Loperamide 2 mg. (milligrams) each, with an expiration date of 6/1/17 and assigned to a resident who is no longer living in the facility. The medication is used to relieve symptoms of diarrhea. -In the pantry refrigerator, the medication storage box contained seven (7) Bisacodyl Suppositories and fifteen (15) Tylenol suppositories 650 mg each. These suppositories were assigned to Resident #4 who expired on 10/13/16.	R161		

Mary Naumann RN 11-25-2017
CO-OWNER

R161 - R999 POC accepted 11/29/17 MBertrand RN/PMC

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R161	Continued From page 1	R161	SEE POC ACTION #1	NLT 12.15.17

Facility policy identifies when medications are no longer needed the manager or the RN is to dispose of the medication or return them to the pharmacy. The facility manager confirmed during the tour that the above medications should have been discarded.

2. Per inspection of the medication cart in the presence of the manager and the Resident Care Attendant (RCA), on 10/31/17 at approximately 10:45 AM, a pre-poured syringe was discovered containing Ativan 0.5 mg. (milligram) =0.25 ml. (milliliter). The medication is identified as belonging to Resident #3. The physician order directs staff to assist with administration of Ativan 0.5 mg. (liquid) by mouth at 2 PM for anxiety/agitation to the resident.

Per facility policy the purpose of monitoring the controlled substance is to 1.) document responsibility for counting and maintaining accurate controlled drug counts and 2.) Aid in prompt and accurate detection of any discrepancies.

Per facility policy at each change of shift the staff counts the bottles/bubble packs of all controlled drugs and matchers the count (s) listed in the resident drug record on the controlled drug count sheets. When this is done, the counts are listed on the Controlled Drug Chain of Responsibility Form with the appropriate date. Both staff members sign/initial the form indicating that the count documented is correct.

The facility manager and the RCA, both confirm at 10:45 AM, that the Registered Nurse pre-pours the liquid anti-anxiety medication and staff document on the controlled medication record

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R161	Continued From page 2 that the medication is present. They do not identify the amount of liquid in the syringe, just that it is present. The facility manager confirms on 11/1/17 during the exit interview that she is responsible for the above issues that were overlooked. See R176 and R177.	R161	SEE POC ACTION #3	NLT 12.15.17
R176 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (4) Medications left after the death or discharge of a resident, or outdated medications, shall be promptly disposed of in accordance with the home's policy and applicable standards of practice. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview the facility failed to dispose of unused medications for 2 applicable residents who no longer reside in the facility. The findings include the following: Per inspection of the medication cart on 10/31/17 at approximately 10:40 AM the following was identified: -A bingo card containing twenty-three (23) tablets of Loperamide 2 mg. (milligrams) each, with an expiration date of 6/1/17 and assigned to a resident who is no longer living in the facility. The	R176		

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R176	Continued From page 3 medication is used to relieve symptoms of diarrhea. -In the pantry refrigerator, the medication storage box contained seven (7) Bisacodyl Suppositories and fifteen (15) Tylenol suppositories 650 mg each. These suppositories were assigned to Resident #4 who expired on 10/13/16. Facility policy identifies when medications are no longer needed the manager or the RN is to dispose of the medication or return them to the pharmacy. The facility manager confirmed on 10/31/17 at approximately 10:40 AM, that the above medications should have been discarded.	R176	SEE POC ACTION #1	NLT 12.15.17
R177 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (5) Narcotics and other controlled drugs must be kept in a locked cabinet. Narcotics must be accounted for on a daily basis. Other controlled drugs shall be accounted for on at least a weekly basis. This REQUIREMENT is not met as evidenced by: Based on observation, record review and confirmed by staff interview, the facility failed to account for an anti-anxiety medication (a controlled substance) for 1 of 4 sampled residents, on at least a weekly basis (Resident #3). The findings include the following: Per inspection of the medication cart in the	R177		

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R177	Continued From page 4 presence of the manager and the Resident Care Attendant (RCA), on 10/31/17 at approximately 10:45 AM, a pre-poured syringe was discovered containing Ativan 0.5 mg. (milligram) =0.25 ml. (milliliter). The medication is identified as belonging to Resident #3. The physician order directs staff to assist with administration of Ativan 0.5 mg. (liquid) by mouth at 2 PM for anxiety/agitation to the resident. Per facility policy the purpose of monitoring the controlled substance is to 1.) document responsibility for counting and maintaining accurate controlled drug counts and 2.) Aid in prompt and accurate detection of any discrepancies. Per facility policy at each change of shift the staff counts the bottles/bubble packs of all controlled drugs and matchers the count (s) listed in the resident drug record on the controlled drug count sheets. When this is done, the counts are listed on the Controlled Drug Chain of Responsibility Form with the appropriate date. Both staff members sign/initial the form indicating that the count documented is correct. The facility manager and the RCA, both confirm at 10:45 AM, that the Registered Nurse pre-pours the liquid anti-anxiety medication and staff document on the controlled medication record that the medication is present. They do not identify the amount of liquid in the syringe, just that it is present.	R177	SEE POC ACTION #3	NLT 12.15.17
R249 SS=D	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation	R249		

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R249	Continued From page 5 7.2.d The home shall assure that food handling and storage techniques are consistent with safe food handling practices. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview the facility failed to assure that food handling and storage techniques are consistent with safe food handling practices. The findings include the following: Per facility tour of the kitchen, in the presence of the Manager on 10/31/17 at 8:45 AM, the following deficient practices were identified: 1.) Kitchen refrigerator was found with two (2) prepared sandwiches in plastic bags with no date as to when they were made; 2.) Two (2) linked sausages in a plastic bag, that was not sealed, not identified as to the contents and was not dated as to when the contents was placed in the refrigerator. The Manager confirmed during the tour that foods should be marked as to the date they are put in use and discarded if not used after 3 days.	R249	SEE POC ACTION #2 MHT 12-15-2017	
R251 SS=F	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.a All food and drink shall be stored so as to protect from dust, insects, rodents, overhead leakage, unnecessary handling and all other sources of contamination. This REQUIREMENT is not met as evidenced	R251		

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R251	Continued From page 6 by: Based on observation and confirmed by staff interview the facility failed to assure that all food and drink is stored to protect from dust, insects, rodents and all other sources of contamination. The findings include the following: Per kitchen tour on 10/31/17 at 8:45 AM in the presence of the Manager the following deficient practices were identified: - Plastic bags containing partially used sugar (brown/white) not sealed; - Partially used bags/boxes of flour, baking soda, pancake mix, powdered sugar and corn starch not sealed or dated as to when they were put in use; - 3 pound canister of of partially used powdered sugar with a scoop stored on the contents; - Partially used box of baking soda with a scoop stored on the contents; - Partially used jar of Nutella (chocolate spread), caked with dried sticky chocolate with no date as to when it was put in use; - Partially used jar of peanut butter, labeled with a resident's first name, with no date as to when it was put in use. Staff confirm that the resident is no longer is in the facility; -Large bag of dried uncooked oatmeal, unsealed, with no label as to the contents nor is it dated as to when it was put in use; - Box of partially used dried cereal not sealed and not dated as to when it was put in use. The Manager confirmed all of the above was found during the tour.	R251	SEE POC ACTION # 2	NLT 12.15.17
R266 SS=F	IX. PHYSICAL PLANT	R266		

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R266	Continued From page 7 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation and confirmed by staff interview the facility failed to maintain a safe, functional, sanitary, homelike and comfortable environment. The findings include the following: Per facility tour on 10/31/17 and 11/1/17 mid morning, in the presence of the Manager, the following unsafe and unsanitary deficient practices were identified: -Hand-i-cap ramp used for emergency exit/entrance and wheelchair access was found with the railing unattached to the frame due to wood rot, with exposed nails, rough chipped paint and slivered wood. The floor base of the ramp was found with cracks and an accumulation of dried/wet leaves that could contribute to slips/falls. The landing at the ground edge was found to be elevated, that could easily be a trip hazard. -Stairway off the left side of the first floor resident rooms, that leads to the exit ramp, is detaching from the building. Nails are exposed, the wood is rotten and the stairway is still available for use. -Stairway off the right side of the first floor resident rooms, that leads to the exit ramp has a very loose metal railing. -The right side of the upper level has a battery operated emergency lighting system that is not functioning. The facility does not have any emergency exit signs on any doors on the first floor;	R266	SEE POC ACTION #4 WLT 12.15.17	

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R266	Continued From page 8 -Dining room found with a ceiling light, located above resident tables, missing the cover and florescent bulbs are exposed; -Kitchen/Dining room found the linoleum flooring cracked and missing pieces of the flooring itself. -Dining room furniture and walls with visual dried spills and food, window treatments caked with dust and grime and a stand fan caked with dust blowing into the kitchen prep area; -Bathroom door on the right side of the first floor has a crack on the right lower panel approximately 12 inches in length with rough edges exposed; -Living room was found with walls that have multiple scuff marks, missing wall paper and a hole approximately the size of a golf ball. Window coverings caked with dust and grime and furniture in need of cleaning; -Resident rooms both upper and lower levels in need of cleaning evidenced with accumulated dust, grime and walls that need cosmetic repairs; -Halls with visible dust, cobwebs and accumulated dust and grime on sprinkler heads. Wall to wall carpeting noted to be taped in place at various locations with visible fraying of carpet fibers. The manager confirms all of the above during the tours. Per facility tour in the presence of the Manager, on 10/31 and 11/1/17 mid morning, resident beds located on both the first and second floors were found with resident bed frames caked with dust and grime. One of the beds was found with sheets that was smeared with a brown dried substance. The Manager confirmed that the beds should be cleaned weekly, but confirms they are dirty and	R266	SEE POC ACTION #4 SEE POC ACTION #5	

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R266	Continued From page 9 need cleaning.	R266		
R999 SS=C	MISCELLANEOUS 4.11 Transfer Prohibited: A license shall be issued only for the person(s) and premises named in the application and is not transferable or assignable. Based on observation of current Residential Care Home License, the facility has failed to notify the licensing agency of a change in management. The findings include the following: Per facility tour on 10/31/17, the facility license located at the entrance of the front door identifies the manager to be the owner. Per interview with current manager, at approximately 11:45 AM, confirmation is made that s/he is unaware if the facility's owner submitted a letter to the licensing agency, requesting a change in management. The new manager took over the position in September 2017. Per interview with the Licensing Chief on 10/31/17, the licensing agency has not received a letter of request to change the name of the manager.	R999	SEE POC ACTION #6	NLT 12.15.17

November 25, 2017

Plan of correction for regulations not met at Willows of Windsor on inspection done October 31, 2017

#1
Violations: Items were found that should have been disposed of to include expired suppositories in unused refrigerator lock box, over the counter medication that was labeled with a prior resident's name was locked in the med cart , and a jar of peanut butter left behind by a prior resident

Plan of correction: Items found were discarded.

Future prevention: Manager will document monthly that items that should be disposed of are removed from the premises.

#2
Violations : left overs and food packages were found that were not dated, sealed or labeled in our kitchen and pantry.

Plan of correction: Items were discarded.

Future prevention: Staff will be retrained on proper dating, labeling and sealing procedures for opened foods. Training will be documented. Manager will spot check for compliance monthly and document.

#3
Violations: Staff was noted to be counting number of, but not to be checking amounts in, individually capped syringes of medication at each change of shift controlled drug count.

Plan of correction: Staff will be retrained in proper visual inspection of each syringe of medication with each controlled med count.

Future prevention: This visual inspection will be documented on the count sheet.

#4. Violations: House required various repairs.

Plan of correction: A new battery was put in an emergency back up light. A crack in a door and small hole in the wall were patched. Frayed carpet and linoleum were repaired. Stairs to doors that are unused were repaired. The leaves were swept off the ramp. Hand rail and ramp was repaired. Flaking paint on the handrail was removed and repainted. A small gradient strip was applied to the end of the ramp. A light that is missing it's cover will be replaced by Dec 15th.

Future prevention: Manager will inspect house monthly to assure repair needs are noted and document.

#5
Violations: House not clean enough

#5 cont

Plan of correction: House was reviewed for any cobwebs. a food splatter was wiped off the wall, dining chairs were washed but still have bleach stains from mopping. Bed rails and window sills were dusted. The stained bedding on an unused bed was removed.

Future prevention: Manager will inspect and document on house keeping monthly.

#6 Violation: Co-owner /RN Mary Naumann is listed on current license instead of Manager/co-owner Patti Hutchins.

Plan of correction: This will be corrected for annual licensure due Jan 1. 2018

Thank you for assisting us to properly meet regulations for our clients. We will have all corrections in place NLT Dec 15, 2017 unless otherwise specified.

Sincerely,

Mary Naumann RN

Mary Naumann, RN

* Also see addendums

NOV 29 2017

POC 176 /161

Citation :Medications not promptly disposed off

Home practice is for staff to dispose of medications right after clients leave.
To assure this is done, Manager will double check and document with 3 days of client leaving that medications are disposed of.

POC 177
See RN's policy. For this client, we are having the doctor change the medication to pill form. Doctor has been called. See underlined addition to the current policy that will be in effect if I decide to allow liquid controlled drugs again , ie for hospice clients.

POC 249. Staff will be retrained on correct labeling, sealing and dating of food. Training verification will in place by Dec 15.

POC 251 Staff will be retrained that all food must be protected from dust insects, rodents overhead leakage, excess handling and contamination. Training verification will be in place by Dec 15 To include not storing scoops with food,or ice.

**Please clarify does rodent proof now mean glass or metal for all foods? Are plastic bags/containers acceptable if sealed?

POC 999. Letter attached.

Thank you.

Patti Hutchins

Patti Hutchins

Mary Naumann

Mary Naumann

POC 177

Willows of Windsor
Policy for Use of Controlled Liquid Medications (updated 11.17)

OLD RN REACTING

1. RN to assess necessity of use of liquid controlled medications on a case by case basis. It shall be general policy to not use liquid controlled medications when possible due to inherent difficulties with accurate measurement of stock bottles.
2. When liquid controlled medications are deemed as Best Care for a client, the RN or manager will add no more than 7 day's worth of pre-filled doses each week to the controlled drug count.
3. Shift to shift count of Pre-filled syringes will align with policy of controlled drug count and medication pass policy of the home. Any controlled drug count discrepancies must be reported immediately to management or the RN.
4. Each pre-filled syringe will be labeled with name, dose, expiration date of the medication.
5. Staff is responsible for verifying the amount of each syringe at each controlled med count, and documenting that each syringe amount and dose was verified.

NEW PART